HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: ....

Ward: ....

PATIENT:

Name: ....

NHI: ....

Ezetimibe with simvastatin

INITIATION

Prerequisites (tick boxes where appropriate)

❍ Patient has a calculated absolute risk of cardiovascular disease of at least 15% over 5 years

and

❍ Patient's LDL cholesterol is 2.0 mmol/litre or greater

and

❍ The patient has not reduced their LDL cholesterol to less than 2.0 mmol/litre with the use of the maximal tolerated dose of atorvastatin

HOSPITAL

I confirm that the above details are correct:

Signed: .... Date: ....